Appendix 11

National Council For Prescription Drug Programs Reject Codes/Messages and Wisconsin Medicaid Edit/Audit Codes/Messages

NCPDP: National Council for Prescription Drug Programs.
M/I: Missing/invalid.

NCPDP Reject Code	NCPDP Message/Explanation	Additional Information
01	M/I Bin	Provider should contact software vendor.
02	M/I Version Number	Provider should contact software vendor.
03	M/I Transaction Code	Provider should contact software vendor.
04	M/I Processor Control Number	Provider should contact software vendor.
05	M/I Pharmacy Number	Provider should contact software vendor.
15	M/I Date Filled/Date of Service	Provider should check date submitted. If valid, provider should contact software vendor.
16	M/I Prescription Number	Provider should check prescription (Rx) number submitted. If numeric, provider should contact software vendor.
18	M/I Metric Quantity	Provider should check metric quantity submitted. If numeric, provider should contact software vendor.
19	M/I Days' Supply	Provider should check days' supply submitted. If numeric, provider should contact software vendor.
20	M/I Compound Code	Provider should contact software vendor.
21	M/I NDC Number	Provider should check National Drug Code (NDC) number submitted. If within range 99900000000-99998999999 or 90000000011-90000000015, instruct provider to not submit Pharmaceutical Care (PC) or compound drug NDC.
28	M/I Date Prescription Written	Provider should check date submitted. If valid, provider should contact software vendor.
30	M/I PA Code and Number	Provider should contact software vendor.
32	M/I Level of Service	Provider should check level of service (LOS). If valid value, provider should contact software vendor.
83	Duplicate Paid/Captured Claim	Provider should check date of service (DOS) and Rx number. If same as another paid claim, provider should resubmit claim with different Rx number.
84	Claim Has Not Been Paid/Captured	Claim denied due to Wisconsin Medicaid edit or audit.
85	Claim Not Processed	Detail not processed because of another detail on claim. No corrective action necessary on this detail at this time. Resubmit.

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continued

NCPDP Reject Code	NCPDP Message/Explanation	Additional Information
88	DUR Reject Error	
93	Planned Unavailable	
99	Host Processing Error	
DQ	M/I Usual and Customary	Provider should check usual and customary charge. If numeric, provider should contact software vendor.
DV	M/I Other Payer Amount	Provider should check other payer amount. If numeric, provider should contact software vendor.
DW	M/I Basis of Days' Supply Determination	Provider should check other payer amount. If numeric, provider should contact software vendor.
DX	M/I Patient Paid Amount	Provider should check other payer amount. If numeric, provider should contact software vendor.
NN	Transaction Rejected at Switch or Intermediary	Provider should check other payer amount. If numeric, provider should contact software vendor.
E4	DUR Conflict/Reason for Service Code	If provider is submitting Drug Utilization Review (DUR) code on compound claim, instruct provider that professional services are not billable on compound claim.
E5	DUR Intervention/Professional Service Code	If provider is submitting DUR code on compound claim, instruct provider that professional services are not billable on compound claim.
E6	DUR Outcome/Result of Service Code	If provider is submitting DUR code on compound claim, instruct provider that professional services are not billable on compound claim.
E7	M/I Metric Decimal Quantity	Provider should check metric decimal quantity. If numeric, provider should contact software vendor.
EC	M/I Compound Ingredient Component Counter Number	Provider should contact software vendor.
ED	M/I Compound Ingredient Metric Decimal Quantity	Provider should check compound ingredient metric decimal quantity. If numeric, provider should contact software vendor.
M5	Requires Manual Claim (Wisconsin Medicaid POS = Unable to be reversed real-time)	Provider should verify that the pharmacy number, date filled/DOS, and prescription number are correct and resubmit. If valid, submit adjustment request on paper.
EE	M/I Compound Ingredient Drug Cost	Provider should check compound ingredient drug cost. If numeric, provider should contact software vendor.
M5	Error Overflow (Wisconsin Medicaid POS = Unable to display additional error messages. Contact Provider Services)	

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Explanation of Benefits (EOB) Message #	Edit/Audit EOB Message Description
005	Charges paid at reduced rate based upon your usual and customary pricing profile.
006	Amount paid reduced by amount of other insurance payment.
009	Recipient name missing. Please correct and resubmit.
010	Recipient is eligible for Medicare. Please bill Medicare first. Indicate Medicare disclaimer on claim if Medicare denied or attach the Explanation of Medicare Benefits if Medicare paid.
012	Service paid at the maximum amount allowed by Wisconsin Medicaid reimbursement policies
014	A discrepancy was noted between the other insurance indicator, and the amount paid on your claim.
020	Claim reduced due to recipient spenddown.
024	Provider certification has been suspended by the Department of Health and Family Services (DHFS).
025	Provider certification has been cancelled by the DHFS.
029	Wisconsin Medicaid number does not match recipient's last name.
050	Payment reduced by recipient copayment.
060	*International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is missing or invalid.
074	No electronic media claims agreement form on file. Please contact Wisconsin Medicaid.
084	Claim denied due to missing or invalid provider signature and/or billing date.
095	Generic substitute invalid. Please correct and resubmit.
100	Claim previously/partially paid on (internal control number) on remittance advice (RA) date (DDMMYY). Adjust paid claim.
114	Schedule 3/4/5 drugs are limited to the original dispensing plus five refills or six months.
116	Procedure or drug code not a benefit on DOS.
137	This claim paid at per diem rate.
146	Non-scheduled legend drugs are limited to the original dispensing plus 11 refills or 12 months.
153	Claim denied due to missing and/or incorrect total billed amount.
158	Quantity billed is missing or exceeds the maximum allowed per DOS.
171	Denied. Claim/adjustment received after 12 months from DOS indicated on claim/ adjustment.
172	Recipient' s Wisconsin Medicaid number not eligible for DOS.
177	Denied. Procedure not payable for place of service or invalid place of service code submitted. Resubmit with correct place of service code for procedure provided.

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EOB Message #	Edit/Audit EOB Message Description
183	Provider not authorized to perform procedure code and/or type of service code.
184	Procedure billed does not correspond with Wisconsin Medicaid age criteria guidelines.
185	Procedure billed is not appropriate to recipient's sex.
201	Performing provider not certified by Wisconsin Medicaid/prescribing Drug Enforcement Agency (DEA) number invalid for NDC billed.
203	Estimated days' supply missing or incorrect.
221	No charge was submitted for this procedure.
224	Quantity billed is missing or incorrect.
228	Medicare Part B deducted charges.
240	Prescription number is missing or incorrect.
242	Prescription date is missing, invalid, after DOS, or exceeds one year. Please correct and resubmit.
247	Procedure code/NDC is invalid, obsolete, or not billable to Wisconsin Medicaid, or this procedure/type of service combination is invalid. Resubmit with valid Wisconsin Medicaid codes for the DOS.
277	Services billed are included in the nursing facility rate structure.
278	Denied. Recipient eligibility file indicates other insurance. Submit to other insurance carrier.
281	Recipient's Wisconsin Medicaid identification number is incorrect. Please verify and correct the Wisconsin Medicaid number and resubmit claim.
287	Claim denied. Recipient is enrolled in a Medicaid HMO or other managed care program.
289	Services performed by out-of-state providers are limited to those prior authorized or emergency in nature.
310	Traditional professional dispensing fee reimbursement policy applied.
322	Service(s) denied/cutback. The maximum prior authorized service limitation or frequency allowance has been exceeded.
324	EDS Federal has recouped payment for service(s) per provider request.
361	No more than two dispensing fees per month per prescription shall be paid.
369	The indicated legend drug shall be dispensed in amounts not to exceed 34-days' supply.
376	The indicated legend drug shall be dispensed in amounts not to exceed a 100-days' supply.
388	Incorrect or invalid type of service/NDC/procedure code/accommodation code or ancillary code billed.
398	Prior authorization (PA) number submitted is missing or incorrect.
399	Date of service must fall between the PA grant date and expiration date.

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EOB Message #	Edit/Audit EOB Message Description
400	Performing provider on the claim must be the same as the performing provider who received PA for this service.
424	Billing provider name/number is missing, mismatched, or unidentifiable. Indicate one billing provider name/number in the appropriate element.
425	Performing/prescribing provider number/DEA number is missing or unidentifiable. Please indicate separately on each detail.
426	Claim denied. Payment is limited to one unit dose service per calendar month, per legend drug, per recipient.
469	Claim is being processed through Special Handling. No action on your part is required. Please disregard additional messages for this claim.
477	Billing provider indicated on claim not allowable as a billing provider. A clinic, facility, or supervising provider must be the billing provider.
498	Pharmaceutical Care code must be billed with a valid LOS.
509	Claim denied. Please verify the units and dollars billed. If correct, refer to Pharmacy Handbook for special billing instructions.
510	Denied. Prior authorization/diagnosis is required for a payment of this service. A valid PA number/diagnosis is required and/or the type of service/procedure must match the approved PA.
511	National Drug Code is only billable as a compound drug.
595	One service allowed per day. This procedure is denied as a duplicate.
614	Wisconsin Medicaid number does not match recipient's first name.
618	Claim denied. Unit dose indicator billed is invalid with NDC billed.
619	Claim denied. Do not indicate "no substitute" on the claim when the NDC billed is for a generic drug.
630	A valid LOS is required for billing compound drugs or PC.
631	Recipient locked-in to a pharmacy provider or enrolled in a hospice. Contact recipient's hospice for a payment of services or resubmit with documentation of unrelated nature of care.
643	Billing provider not certified for the DOS.
683	Qualified Medicare Beneficiary Only recipient is allowable only for coinsurance and deductible on a Medicare crossover claim.
698	Recipient not eligible for Medicaid benefits.
751	Denied. No substitution indicator invalid for drugs not on the current Wisconsin Maximum Allowed Cost (MAC) list.
843	All three DUR fields must indicate a valid value for prospective DUR. A valid LOS is also required for PC reimbursement.
846	Denied. This procedure code is not valid in the pharmacy Point-of-Sale (POS) system. Please resubmit on the HCFA 1500 using the correct HCFA Common Procedure Coding System (HCPCS) procedure code.

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EOB Message #	Edit/Audit EOB Message Description
852	Denied. Quantity must be a whole number for this NDC. Correct and resubmit.
853	Fill date is missing, incorrect, or contains future date.
877	The quantity allowed was reduced to a multiple of the product' s packaging size.
887	Default prescribing physician number XX5555555 was indicated. Valid numbers are important for DUR purposes. Please obtain a valid number for future use.
888	Default prescribing physician number XX9999991 was indicated. Valid numbers are important for DUR purposes. Please verify that physician has no DEA number.
907	Our records indicate you have billed more than one unit dose dispensing fee for this calendar month. Reimbursement for this detail does not include unit dose dispensing fee.
916	Pharmaceutical Care codes are billable on non-compound drug claims only.
920	Denied. A discrepancy exists between the other coverage (OC) indicator submitted and the OC information on the file for the recipient. Please verify and resubmit.
922	Duplicate component billed on same compound claim.
935	Invalid billing of procedure code.
957	Other coverage indicator is missing or invalid. Please correct and resubmit.
960	Denied. These supplies/items are included in the purchase of the durable medical equipment item billed on the same DOS.
976	Resubmit on paper for special handling.
979	Pharmaceutical Care code must be billed with a payable drug detail.
994	Compound drugs require a minimum of two components with at least one payable Medicaid covered drug.
996	Denied, limitation exceeded.